DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/26,2012 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SU-PLIER/CLIA IDENTIFICATION N. MBER: | (X2) M ¹ | | LE CONSTRUCTION | (£A) ETATE SURVEY COMPLETED | | | |
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| | | 445235 | B. WING | | | 01/17/2012 | | | |
| | ROVIDER OR SUPPLIER | ABILITATION AND NURSING HOM | STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PROVIDER'S PLAN OF CORREC' PREFIX (EACH CORRECTIVE ACTION SHOULD FOR CROSS-REFERENCED TO THE APPRINT DEFICIENCY) | | | JLD BE COMPLETION | | |
| | SPREAD, LINENS The facility must es Infection Control Prisafe, sanitary and of to help prevent the of disease and infection Control The facility must es Program under which (1) Investigates, con in the facility; (2) Decides what prishould be applied to (3) Maintains a reconsistance of the facility; (2) Preventing Spre (1) When the Infection determines that a reprevent the spread isolate the resident. (2) The facility must communicable disease from direct contact will trace (3) The facility must hands after each direct contact will trace (3) The facility must hands after each direct contact will trace (3) The facility must hands after each direct contact will trace (3) The facility must hands after each direct contact will trace (3) The facility must hand washing is independent of the facility must hand washing is must hand professional practice. | of Program Stablish an Infection Control ch it - introls, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective infections. The add of Infection ion Control Program resident needs isolation to of infection, the facility must to prohibit employees with a ase or infected skin lesions with residents or their food, if ansmit the disease. It require staff to wash their rect resident contact for which licated by accepted | F 4 | 141 | 1. Corrective action for residents affected: a) Boxes of gloves were put rooms affected by Unit Managers. b) The DON and Nursing St completed an audit of all rooms for gloves; and for rooms to be in compliance. 2. Identification of others who considered by the deficient practice a) All residents have the potential to be affected this practice. 3. Measures put in place to ensure deficient practice does not reocce a) The Nurse Educator insernursing staff to visually in glove boxes during each provision of care, to replate glove boxes when found the empty or almost empty, a location of supplies. b) The Nurse Educator inserned housekeeping staff to visually in supplies. b) The Nurse Educator inserned housekeeping staff to visually in the supplies. b) The Nurse Educator inserned housekeeping staff to visually in the supplies. b) The supplies almost empty, and the location of care, to replace boxes when found to be ealmost empty, and the location of supplies. | taff resident and all se. ould be e: e e d by re ur: rviced nspect ace to be and the rviced ually ag each e glove empty or | 1/17/12 1/17/12 2/03/12 | | |

DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

officiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program partic: pation.

| | | AND HUMAN SERVICES | | | | | FORM. | 20126/2012 FPR:2VED 44 |
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| CENTERS FOR MEDICARE & MEDICAR: SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER SUPPLIER/CLA IDENTIFICATION NUMBER: | | | (X2) MULTIP E CONSTRUCTION A. BUILDING | | | | OME NO. 0935 0391 (X3) I ATE SURVEY COMPLETED | |
| | | 445235 | B. WIN | NC | | | *o | C 7/2012 |
| | ROVIDER OR SUPPLIER ARD TERRACE REHA | ABILITATION AND NURSING HO | ΝE | 1530 | MIDDLE | S, CITY, STATE, ZIP CODE TENNESSEE BLVD BORO, TN 37130 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | IX | (EAC) | OVIDER'S PLAN OF CORREC H CORRECTIVE ACTION SHO REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| F 441 | This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide necessary personal protective equipment for resident care for five resident rooms (#13, #26, #29, #31, and #36) of ninety-three residents. The findings included: Observations on January 17, at 8:50 a.m., 10:30 a.m., and 2:00 p.m. revealed rooms, 13, 26, 29, 31, and 36 had empty boxes in the racks where the gloves were stored for use when providing | | F | 441 | 4. Systems to monitor the effectiveness: a) Room rounds being done 5 days weekly X 4 weeks by DON, Nurse Educator, Unit Managers, and Central Supply Director with any deficiencies corrected immediately and re-education as necessary. b) Findings will be reported monthly to the QA Committee: Administrator, Director of Nursing, Medical Director, Unit Managers, Restorative Manager, Nurse Educator, Social Services Director, Medical Records Nurse, Dietary Manager, Activity Coordinator, MDS Coordinator, | | | Ongoing |
| | January 17, 2012, a room, revealed it is available to al! staff are to wear gloves care to residents. | Director of Nursing (DON) on at 3:00 p.m., in the conference facility policy for gloves to be for resident care and staff whenever they are providing | | | 1.6 | Housekeeping Director, Manager, Maintenance I Admissions Coordinator Business Office Manage | Therapy Director, r, and er. | |
| F 465 SS=D | SAFE/FÚNCTIONA E ENVIRON | AL/SANITARY/COMFORTABL | F | 465 | affected | Bathroom was immedia cleaned and wash basin | tely removed | 1/17/12 |
| | The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. | | | | b) | as "stopped up" and ma | reported | 1/17/12 |
| | This REQUIREMENT by: | NT is not met as evidenced | ; | | c) | repaired this. Housekeeping immedia cleaned the bathroom at | | 1/17/12 |

FORM CMS-2567(02-99) Previous Versions Obsolete

#53.

Based on observation and interview, the facility

environment for three resident rooms, #29, #43,

failed to maintain a clean and sanitary

Event ID: MCKH11

Facility ID: TN7502

If continuation sheet Page 2 of 3

maintenance work was

completed.

| STATEMEN OF DEFICIENCIES AND PLAN OF CORF (CTION LIENTIFICATION NUMBER: 445235 | | The second | IULTF _ ILDING | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | | 3. WI | พร | | C 01/17/2012 | | |
| | ROVIDER OR SUPPLIER | ABILITATION AND NURSING HO | ME | 153 | ET ADDRESS, CITY, STATE, ZIP CO 10 MIDDLE TENNESSEE BLVD IRFREESBORO, TN 37130 | DE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 465 | The findings included Observation of room 8:50 a.m., revealed around the bowl as flushed out. Continual unlabeled basin on brief and tissues rointerview on Januar the resident's room the toilet bowl was and tissues and a in the basin. Observation of room 9:20 a.m., revealed the sink along with both of which were trash was on the floobservation of the room at 10:30 a.m., revealed Interview on Januar room #43, revealed the findings. Observation of room 17, 2012, at 9:30 a. and tissue in the toilet the room at 10:40 a still unflushed in the January 17, 2012, at 9:31, and the sink along with the room at 10:40 a still unflushed in the January 17, 2012, at 9:31, and the sink along with the sink along with the room at 10:40 a still unflushed in the January 17, 2012, at 9:31, and the sink along with t | ed: m 29 on January 17, 2012,, at the toilet had brown debris all if brown liquid had been used observation revealed an the floor with an incontinent lled up in the bottom. During ry 17, 2012, at 9:00 a.m., in the nurse on duty confirmed dirty; the basin was unlabeled; colled up incontinent brief were two trash cans in the room, overflowing with trash and for around them. Continued from an January 17, 2012, at the same conditions. Ty 17, 2012, at 10:35 a.m., in the housekeeper confirmed m 53 during tour on January m., revealed unflushed stool let. Continued observation of a.m., revealed the stool was a toilet. During interview on | F | 465 | d) Unlabeled gallon juremoved from bathred discarded by Centra Director. e) Full audit of resider presence of labeling basins and removal unlabeled items by Supply Director, Che Managers. f) Trash was immediating affected rooms by housekeeping. g) Toilet was immediating affected room by Manager. 2. Identification of others was affected by the deficient practice. 3. Measures put in place to deficient practice does not a fection of the supportance of the support of th | room and all Supply at rooms for a on wash of any Central NAs, and Unit tely emptied y tely flushed Unit who could be actice: attential to be ensure reoccur: inserviced ensure second second staff to soiled linen ent room second sec | 1/17/12 2/03/12 1/17/12 1/17/12 2/03/12 1/17/12 |
| | | | | | | | |

PRINTED: 01/26/2012 F. RW 45 PP OVED CMB NO. 1906-0391

| STATEMENT OF DEFICIENCIES (X.) PROVIDER/ST PPLIER/CLIA AND PLAN OF CORRECTION CENTRAL CANDUMBER. 445235 | | | (Y2' at A. BUIL | | LE CONSTRUCTION | | COMPLETED | |
|----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|----|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|----------------------------|--|
| | | B. WIN | | | | C 01/17/2012 | | |
| NAME OF PROVIDER OR SUPPLIER BOULEVARD TERRACE REHABILITATION AND NURSING HOL | | | | 15 | ET ADDRESS, CITY, STATE, ZIP CO 30 MIDDLE TENNESSEE BLVD URFREESBORO, TN 37130 | DE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFII TAG | | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | I SHOULD BE | (X5) COMPLETION DATE | |
| F 465 | Continued From pa | | F 465 | | d) Housekeeping clear was evaluated and r put in place to empt to room and clean t | new schedule ty trash room he bathrooms | 1/17/12 | |
| | 8:50 a.m., revealed around the bowl as flushed out. Contin | of room 29 on January 17, 2012,, at evealed the toilet had brown debris all bowl as if brown liquid had been Continued observation revealed an asin on the floor with an incontinent sues rolled up in the bottom. During January 17, 2012, at 9:00 a.m., in s room, the nurse on duty confirmed will was dirty; the basin was unlabeled; and a rolled up incontinent brief were | | | on their first round. e) The Nurse Educato nursing staff on imi disposal of waste. | r inserviced nediate | 2/03/12 | |
| | brief and tissues ro interview on Janua the resident's room the toilet bowl was | | | | a) Room rounds being weekly x4 weeks to compliance by Hou Supervisor and/or A with any deficiencie immediately and re | done 5 days monitor for sekeeping Administrator es corrected | Ongoing | |
| | 9:20 a.m., revealed the sink along with both of which were trash was on the flo observation of the 10:30 a.m., revealed Interview on Janua | m 43 on January 17, 2012, at d an unlabeled gallon jug under two trash cans in the room, coverflowing with trash and por around them. Continued room on January 17, 2012, at ed the same conditions. Bry 17, 2012, at 10:35 a.m., in d the housekeeper confirmed | | | necessary. b) Findings will be represented from the part of the pa | Committee: actor of birector, Unit ive Manager, cial Services decords hager, Activity Coordinator, | Ongoing | |
| | 17, 2012, at 9:30 a and tissue in the to the room at 10:40 a still unflushed in the January 17, 2012, a | rvation of room 53 during tour on January 012, at 9:30 a.m., revealed unflushed stool ssue in the toilet. Continued observation of om at 10:40 a.m., revealed the stool was afflushed in the toilet. During interview on ary 17, 2012, at 10:45 a.m., the excepter confirmed the toilet was unflushed ad stool in it. | | | Manager, Maintena Admissions Coordi Business Office Ma | nce Director, nator, and | | |
| | | | | | | | | |